

Harm Reduction in Clinical Practice

By Stanton Peele, PhD, JD

Harm reduction is a term best known in the substance abuse field as a way of reforming drug policy. Replacing zero-tolerance policy, it recognizes the certainty that some people will continue to use drugs, and therefore drug use will remain a fact of life in our society. With this in mind, harm reduction seeks to protect drug users - and non-drug users exposed to drug users - from the worst consequences of such use. Harm can occur for even casual drug users, but the worst consequences are likely to befall heavy users. In this way, harm reduction is a treatment strategy that may also be appropriate for alcoholics.

Research results are discouraging - and encouraging

By now it is clear that standard, one-on-one or group addiction therapy in the United States is not sufficiently comprehensive to deal with the range of alcoholism problems facing it. Only about one in four alcohol-dependent individuals enters treatment (including AA) at all, according to the National Alcohol Epidemiologic Survey (NLAES), the largest household survey of Americans' drinking ever conducted (Dawson, 1996). Only a further minority of this proportion seriously engages in available treatments (one rule of thumb derived from AA's biannual surveys is that one in ten of those who come to AA continues to engage for as long as a year).

Moreover, the largest trial of psychotherapy thus far, Project MATCH, was completed in 1996. It produced results that could be disheartening to standard treatment approaches (see Project MATCH Research Group, 1997). MATCH - in which treatments were designed by leading practitioners and researchers, with cutting-edge manuals for guidance, in which therapists were carefully trained and closely supervised, and where patients were high-prognosis volunteers - found that few alcoholics abstained for even as long as a year following treatment. MATCH used three treatments (12-step facilitation, coping skills therapy, and motivational enhancement therapy) and two treatment groups - a strictly outpatient group and a group which first underwent hospital treatment. Of the former group, fewer than one in ten (nine percent) abstained throughout the first follow-up year. Of the latter, only about a third (35 percent) did.

Yet, clients seemed to benefit from the treatment. Liver functioning for the group improved and their drinking problems were reduced. Representatives of the government sponsor of the research, NIAAA, viewed the project and the treatments it included as highly successful. However, in order to do so, the investigators couched the results in non-abstinence terms, pointing out that subjects began treatment averaging 15 drinks on every drinking day, which included 25 days of the month, while after treatment they were drinking on only six days of the month, and having only three drinks per occasion.

One further aspect of Project MATCH that stood out was the minimal amount of therapeutic contact required to produce its results. Twelve-step facilitation and coping skills therapy required only 12 one-hour sessions, while motivation enhancement included only four sessions. Moreover, subjects on average attended only two-thirds of assigned sessions. Motivational enhancement therapy (see "What if they aren't ready? Increasing Motivation for Treatment,") consists of encouraging alcoholics to examine their lives and values and to decide for themselves that, on balance, they want to seek sobriety. This therapy places the weight of decision-making - and also the mechanics of changing drinking habits - on the individual.

In its brevity and the reliance on clients themselves, the motivational enhancement component of Project MATCH resembles brief interventions. These are usually physician-initiated interactions with patients in which doctors provide feedback on the level of a person's drinking, arrive with the patient at goals (usually for reducing rather than quitting drinking), and check up during subsequent office visits on the patient's success at achieving these. Tested in numerous clinical trials, brief interventions have by now shown the greatest success, as measured by research outcomes, of any treatment for drinking problems (Babor et al., 1997; Fleming et al., 2002; Miller et al., 1995). At the same time, along with motivation enhancement, they are the least costly counselor-assisted therapies and are highly cost-effective (Fleming et al., 2002; Miller et al. 1995). (Brief interventions strategies have also shown success in the areas of smoking and weight reduction.)

While brief interventions are restricted generally to non-dependent drinkers, the Project MATCH population was nearly all alcohol-dependent, and at a fairly high level of dependence. Thus, MATCH suggests that benefits of brief interventions relying on patient initiatives and compliance have greater generalizability. One further aspect of MATCH should be noted in this regard, however. Although there was minimal therapist contact, and especially so in the motivational enhancement therapy component, there was frequent, regular follow-up contact for the purpose of performing research assessments. In other words, subjects knew and anticipated that Project personnel would be in touch with them to see how they were measuring up.

The treatment landscape

The Project MATCH results might have prepared us for the outcome of another year-long assessment announced in the prestigious New England Journal of Medicine (Krystal et al., 2001). Designed to assess the benefits of naltrexone for a highly alcoholic population of veterans, the study instead found no difference in outcomes for the group receiving naltrexone for the full year, naltrexone for three months and placebo thereafter, and placebo for the full year.

This, after naltrexone had been touted as the first reliable pharmacological therapy for alcohol dependence. Once again, it was not that clients showed no improvement. Combined with unspecified 12-step counseling, the treatments (including placebo) once again produced little abstinence. Nonetheless, while subjects had been drinking on two-thirds of days at the beginning of the year, by the end they had cut their drinking days to one-quarter of this frequency, as well as drinking approximately 25 percent less on each drinking day.

The Project MATCH results, at least, occurred with volunteer, non-criminal, socially stable subjects. Yet few of these alcoholics could abstain for even a year following treatment. These outcomes with a propitious population show us that to insist on having patients who desire to abstain - and are capable, or largely so, of abstaining - is to disregard the bulk of alcoholic and drug-abusing patients. Restricting treatment to those most motivated and able to quit entirely is to select those who actually need therapy the least. Yet this is the principle according to which nearly all treatment is conducted in the U.S.

This treatment landscape in the U.S. contrasts with an international movement in drug policy towards harm reduction. Harm reduction takes as its point of departure that few people quit drugs at any given time, and that, therefore, policies have to be in place for reducing the harms experienced by those who continue to use. One example is clean needle programs, which help prevent the spread of AIDS among IV drug users. Programs shifting drug users to non-injectables - such as methadone - are based on a similar strategy for preventing worst-case outcomes. Such programs also encourage regular contacts with medical or professional staff that help the user receive treatment for other medical conditions and to preserve their health in other ways.

The concept of harm reduction has taken hold in Europe - where, unlike the United States - every national government endorses or provides needle exchange programs. It has had a certain amount of penetration in the U.S. as well. What follows are methods for counselors to deal with addicts and alcoholics, which are consistent with the harm reduction ideology. This often involves counselors in whole new ways of thinking about clients and the therapeutic relationship. To the extent that counselors can adopt these tools they often find that they can improve their outcomes, and thereby reach more people.

Harm reduction therapy

In the U.S., virtually no treatment program officially endorses - or even tolerates - anything but abstinence. This is emphasized by the virtual universal reliance by treatment programs on AA and related support programs in combination with treatment. In practice, what this means is that clients often drop out of treatment when they realize they are not meeting the total abstinence requirements of the program, or they are judged to be failing since they are not meeting those requirements. Indeed, for a clinician to acknowledge that he or she tolerates drinking by clients would ordinarily mean the counselor will himself or herself be asked to leave the program. At the same time, of course, therapists, even in this environment, make many accommodations for clients who they feel are making a serious effort to change.

If a strictly traditional approach had been applied to Project MATCH or the naltrexone trial, subjects might have been rejected as clients, or they would have quit, throughout the course of the treatments and their follow-up. Yet, in both cases, there was broad improvement among the subjects. Moreover, their failure to achieve or adhere to abstinence regimens is, by all indications, typical for alcoholics overall, even those who volunteer for treatment. And, were counselors better able to tolerate failures to abstain, a broader array of patients would be available for treatment, including the very many people who now fall totally outside the treatment net.

What does this mean for counselors? According to the harm reduction approach, the goal is reduction in negative outcomes, and improvement in drinking practices, whether fewer days of drinking (i.e., more abstinence) or fewer drinks (less bingeing) on drinking occasions. Even when drinking, the emphasis is on avoiding risky situations. This notably includes driving. Other such situations include arenas where people may incur criminal penalties, lose a job, engage in violence, and otherwise experience negative outcomes over and above those due purely to the direct effects of drinking.

To take a practical example (one that might admittedly seem scary to many counselors), if a man is unwilling or unable to give up drinking, it could still be highly therapeutic for him to restrict his drinking to his home. In this case, he could avoid confrontations with the law, the possibility of driving and other accidents, and other negative outcomes that can be piled onto his drinking problem to guarantee he cannot emerge from their combined weight for decades. Can you as a counselor practice such an approach? The answer to this involves a host of individual and situational factors. These include the therapist's tolerance for working in a different fashion from those around him or her, the openness of fellow counselors or of supervisors, the availability of nontraditional therapy outposts, like AIDS-prevention or needle-exchange networks, and many other conditions.

Let us focus in our discussion here on therapeutic techniques and attitudes. Such an approach requires primarily non-judgmental caring (Marlatt et al., 2001, refer to compassionate pragmatism). That is, the therapist must convey that he or she is concerned for the patient's well being, and wants to see improvement. But the therapist then does not conclusively reject the individual who continues to drink, even with problems, and even with serious problems, so long as the client is showing long-range positive movement. Improvement includes not only fewer alcohol-specific problems, but also improved relationships with others, performance at work, maintenance of health, etc. The therapist must keep in mind that, after all, if the client leaves the counseling setting altogether, then the counselor has no leverage to encourage and monitor progress. And, of course, we need to consider what human contact and care even those alcoholics who have currently abandoned hope of improvement may receive.

Learning from brief interventions

What is the average counselor to make of the fact that treatments involving a couple of sessions can produce substantial changes in behavior? The idea underlying brief interventions and motivational enhancement is that the counselor acts as a positive force for the individual, and that the relationship continues over time. Frequency is not the primary measure of therapeutic interaction, but duration. It is better to have a bad session or period and to have the client return over time, and to have some contact to reinvest the person in the change effort, than to express disaffection or to censure patients for each negative incident they experience. Indeed, the optimal program is one that has the best chance of guaranteeing that patients will see the counselor again on a voluntary basis. Keep in mind that the typical brief intervention program occurs within ongoing primary care doctor-patient relationships. Clients then know that they will be held accountable for creating and tracking their own progress, on which they will have to report, and that failures to show progress are strictly their own, although their counselor cares and will learn about it.

Typical counselor comments in this setting include, "John, we meet again in ____ weeks/months, on _____. What goals do we hope to have achieved when we meet again? What do you need to do to make sure these happen? Is there anything my agency or I can provide to help you do this? What are the signs we are looking for to see that you have made the progress we hope for? John, I may call you some time - maybe more than once - before you return, to chat with you about how you are doing and to make sure we are on track. Do you mind? Or, how about if you call me for a quick chat? John, I want you to know I have great confidence in you to make the changes we discussed. I know you have had some problems in your life, but you have also had many successes that we have discussed. And I know that when you set out to change something in your life, you can do so. I'll bet on it."

Of course, even when John is not showing progress, there is a need to remain in contact with him, to show that we remain concerned. Remarkably, at some point in the future, John will show up ready and able to do those things that he seems incapable of now.

But harm reduction extends beyond the drinking and drug use in which the individual is engaging. The goal is to move clients to a more secure footing in life, to help them to resolve other problems, and to encourage better health and functioning. Thus, the harm reduction counselor is highly attuned to other needs clients have, and to the possibility they can be referred beneficially to other health professionals, social service agencies, et al. The underlying thinking is that the more socially stable, healthy, and productive people can be, the better decisions they will make about their substance use. And, in any case, their lives and health can be made better even in the absence of distinct reductions, or cessation of, substance use and abuse.

Like a latter-day Mother Theresa

Among other things, the image of addiction treatment and counseling may need to change. Now, counselors typically see themselves like a latter-day Mother Theresa. At least, they feel that responsibility for change is on their shoulders. Therapists might assume more humility. Like the parent who has no emotional outlet but his or her children, the danger is that the clucking chicken will be so invested in the outcomes of his or her charges that they will never learn to function for themselves at whatever level they can ultimately achieve. Lack of perfection in a client - like lack of perfection in ourselves - is to be expected. This is not to gainsay the chance for something better for all of us. But it is to take tolerance as a powerful therapeutic tool. Perhaps some time in the future there will be something superior to naltrexone in the way of a pharmacotherapy for addiction. But there will always be room for the enterprise of encouraging the halting, imperfect improvement of the human species.

Stanton Peele, PhD, JD, a psychologist and attorney in Morristown, New Jersey, is a fellow of the Drug Policy Alliance. His highly influential publications on addiction include *Love and Addiction*, *The Meaning of Addiction*, *Diseasing of America*, and *The Truth About Addiction and Recovery*. He is a winner of the Mark Keller Award, presented by the Rutgers Center of Alcohol Studies for outstanding contributions to the field.

References

Babor, T., & Grant, M. (Eds.) (1997). Project on identification and management of alcohol related problems: A randomised clinical trial of brief interventions in primary health care. (Geneva: WHO).

Dawson, D.A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20, 771-779.

Fleming, M.F., Mundt, M.P., French, M.T., Manwell, L.B., Stauffacher, E.A., & Barry, K.L. (2002). Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis. *Alcoholism:*

Clinical and Experimental Research, 26, 36-43.

Krystal, J.H., Cramer, J.A., Krol, W.F., Kirk, G.F., & Rosenheck, R.A. (2001). Naltrexone in the treatment of alcohol dependence. *New England Journal of Medicine*, 345, 1734-1739.

Mariatt, G.A., Blume, A.W., & Parks, G.A. Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13-21.

Miller, W.R., Brown, J.M., Simpson, T.L., Handmaker, N.S., Bien, T.H., Luckie, L.F., Montgomery, H.A., Hester, R.K., and Tonigan, J.S. (1995). What works?: A methodological analysis of the alcohol treatment outcome literature. In R.K. Hester and W.R. Miller (Eds.), *Handbook of alcoholism treatment approaches* (2nd Ed., pp. 12-44). Boston: Allyn and Bacon.

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29.